Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: ( ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Clinic for Special Surgery 900 12th Ave Fort Worth, TX 76104	MDR Tracking No.: M4-03-6161-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Continental Casualty Company C/o Burns, Anderson, Jury & Brenner Box 47	Date of Injury: Employer's Name: Advance Health PCS Insurance Carrier's No.: 3A809948

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The fee generated for the services rendered to this patient are fees we charge all insurance carriers whose insureds are treated at this facility, whether under the auspices of the TWCC or insured through the Department of labor, traditional indemnity insurance, or managed care. This facility itemizes its services in an identical fashion for work-related and work-unrelated billing and uses identical fees for all charged services for all types of insurance. The basis for the itemized fees charged by this facility is not arbitrary. Rather, it is based on over a decade of experience in evaluating facility charges in this community by our Medical Director, that includes analysis of the fees of local surgical facilities.

Principle Documentation:
1. Table of Disputed Services
2. Operative Report
3. Discharge Summary
4. UB-92
5. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

As the party seeking relief, Provider has the burden to show that the amount of reimbursement it seeks is fair and reasonable reimbursement within the meaning of section 413.011 of the Act. However, Provider has furnished no persuasive evidence to show that the amount of reimbursement it seeks is consistent with the statutory mandate to achieve effective medical cost control, or that the amount does not exceed the fee charged for similar treatment of an individual or an equivalent standard of living and paid by someone acting on the individual's behalf, or that the amount is based, in part, on the increased security of payment afforded by the Act. Accordingly, Povider has submitted no evidence to show that the amount it seeks if fair and reasonable reimbursement.

Principle Documentation:
1. Position Summary
2. EOB
3. CMS-Pub.60AB
4. Nevada Administrative Code Sections 616C.117 through 616C.230
5. 114.3 CMR 40.00: Rates for Services Under M.G.L.
6. Pennsylvania Medical Fee Review Section
7. SOAH Decisions
8. Medical Dispute Resolution Decisions

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
05/01/02	Ambulatory Surgery	1	$276.44

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

1. This dispute relates to services provided in an Ambulatory Surgical Center (ASC) and not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as

directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

After reviewing the documentation provided by both parties, it appears that neither party has provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307). After reviewing the services, the charges, and both parties' positions, it is evident that some other amount represents the fair and reasonable reimbursement.

During the rule development process for facility guidelines, the commission contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for ASC services. The result of this analysis is a recommended range for reimbursement of workers' compensation services provided in an ASC. In addition, the Commission received information from both ASCs and insurance carriers in the recent rule revision process. The commission considered this information in order to find data related to commercial market payments for the services. This information provides a good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (from 173.9% to 226.5% of Medicare for the year 2002). Staff considered the information submitted by the parties and the issues related to the specific procedures performed in this dispute. Based on this review staff selected a reimbursement amount in the lower end of the Ingenix range. In addition, reimbursement for secondary procedures were reduced by 50% consistent with standard reimbursement approaches. The total amount was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the recommended amount, discussed the facts of the individual case, and selected the appropriate "fair and reasonable" amount to be ordered in the final decision.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that the fair and reasonable reimbursement amount for these services is $1,176.44. Since the insurance carrier paid a total of $900.00 for the services, the health care provider is entitled to an additional reimbursement in the amount of $276.44.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.1 and 133.307

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of $276.44. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

	Marguerite Foster	September 22, 2005
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.